Arizona Dept. of Health Services
Division of Behavioral Health Services

Encounter Tidbits

Arizona Department of Health Services

September 2003

Encounter Tidbits is a monthly publication of the Arizona Department of Health Services, Division of Behavioral Health Services, Office of Program Support Services
150 North 18th Avenue, 2nd Floor, Phoenix, AZ 85007
www.hs.state.az.us/bhs

Edit Alerts

An Edit Alert is a faxed and e-mailed notice of system enhancements or changes. The Office of Program Support strives to ensure any system enhancements or changes are communicated to all program participants in an accurate and reliable manner. Edit Alerts will be distributed when the information is first made available and again with the following monthly publication of the Encounter Tidbits.

** There are no Edit Alerts this month. **

HIPAA Corner. . . .

What is Protected Health Information (PHI)?

Protected Health Information means individually identifiable information relating to the past, present or future physical or mental health or condition of an enrolled person, the provision of health care to an enrolled person, or the past, present or future payment for health care provided to an enrolled person. It does not include individually identifiable information in education records covered by the Family Educational Right and Privacy Act, as amended, 20 U.S.C. 1232g and 1232g(a)(4)(B)(iv); education records, files, documents and other materials which contain information directly related to a student and which are maintained by an educational agency or institution or by a person acting for such agency or institution; and employment records held by a covered entity in its role as an employer.

What is a Business Associate?

Business Associates perform or assist in the performance of functions or activities involving the use or disclosure of protected health information on behalf of ADHS/DBHS including claims processing or administration; data analysis, processing or administration; utilization review; quality assurance; billing; practice management; or repricing; or provide legal; actuarial; accounting; consulting; data aggregation; management; administrative; or financial services where the provision involves the disclosure of protected health information.

AHCCCS Encounters Error Codes

H280 – Encounter Not Eligible to Adjust

Encounters are pending because the adjustment submitted does not match the original. Encounters submitted for adjustment must match the provider and client ID numbers from the original encounter. Encounters pending for this reason must be *voided* instead of corrected.

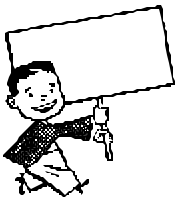
R295 – Medicare Reported But Not Indicated

The Medicare (MDC) Approve and MDC Deduct fields must be blank if the recipient does not have Medicare, otherwise the encounter will pend. If the recipient has Medicare but Medicare denies the service, report zero (0) in the MDC Approve, MDC Deduct and MDC Paid fields. Please refer to AHCCCS PMMIS system RP150 Inquire Medicare Coverage screen. This allows Contractors to review the Medicare information that AHCCCS has on file.

P353 – Rate Not Found on Provider Type Table

Review the field's involved and all relevant data on the encounter. The most common error is that the provider is using a procedure code that is not listed under his specific provider profile. Refer to the Provider's Category of Service found in the AHCCCS system - PR090 (Provider Profile Screen). Any problems or questions contact your Technical Assistant.

These three errors account for 28.42% of the pended encounters at AHCCCS.



Who's Who in the Division of Behavioral Health…..

What is the Office of Grievance and Appeals?

The Office of Grievances and Appeals maintains a grievance system, which provides for an administrative resolution of disputes for members, subcontractors, and providers or non-contracting providers, in accordance with state and federal regulations, statutes and standards. In addition to the grievance system, DBHS has designated specific staff members to act as ombudspersons, advocating to resolve problems or issues raised by members or providers. The Office of Grievance and Appeals is responsible for the management and implementation of the grievance system within DBHS, and monitoring at the RBHAs.

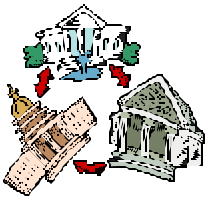
AHCCCS Pended Encounters

Reason Code "D001" has been removed from the valid Reason Code List. RBHAs will need to select an alternate Reason Code or submit a request to OPS for additional Reason Codes. Reason codes D002, D012, and D014 have been modified to fit a wider scope.

Updated Valid Reason Code List:

REASON CODE	DESCRIPTION
A001	Per RBHA review, not a duplicate encounter
D002	Exact or near duplicate encounter found
D003	Combining service with a previous encounter
D004	Medicare / TPL paid encounter in full
D005	Correcting a RBHA system error
D006	Re-pricing encounter
D007	Reporting encounter as Tobacco Tax Fund
D008	Correcting AHCCCS pended encounter
D009	Conflicting HCFA-1500 / UB-92 encounters
D010	Medicare coverage indicated but not billed
D011	Rate not on Provider table
D012	Recipient not AHCCCS eligible during entire dates of service
D013	Provider terminated or not valid during dates of service
D014	Units / accommodation days exceed maximum allowed
D015	Reporting encounter as Subvention (State funds)
D016	Service for IHS Provider should be billed through TRBHA

What is House Bill 2003?



House Bill 2003 provides $50 million of new monies from the tobacco litigation settlement to be spent on persons with serious mental illness, in particular those with Diagnostic and Statistical Manual IV diagnosis of 295 (schizophrenia), 296 (major depressive disorder), 297 (delusional disorder), and 298 (other psychotic disorder). The funds shall be expended on any of the following service areas: housing, recovery support services, vocational rehabilitation, and specialized assessment (extended evaluation). Each regional behavioral health authority proposal has distinct intervention strategies in implementing House Bill 2003. The Bill also authorizes the Arizona Department of Health Services to release $300,000 (from the $50M) to the Office of the Auditor General for the purpose of conducting a performance audit. Bureau staff conducted over 236 comprehensive medical record and client information system data validation studies at the regional behavioral health authorities for the House Bill 2003 legislative appropriations.

Is it Fraud or Abuse? Or Both?

Fraud is defined as the intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law (42 CFR § 455.2).

Abuse is defined as provider practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program (42 CFR § 455.2).

The real difference between fraud and abuse is the person's intent. The line between them is not a black and white issue. Activities commonly thought of as “fraud and/or abuse” are, but not limited to, services billed but never performed, under the table pay-offs, embezzlement of program funds, and kickbacks. Those activities can be classified fraud since they involve the intent to gain or obtain benefits. However, you must determine if the person(s) are intentionally making coding or billing errors for the services actually being provided to clients. The key to determining whether a submitted claim is fraudulent, the person or persons may be acting in deliberate ignorance or with reckless disregard for procedures. Proof of specific intent to defraud is not a requirement to prove whether there was fraud or abuse on the part of the provider.

What is a Habilitation Provider?

A Habilitation Provider (Provider Type 39) is a home and community based service provider certified through the Department of Economic Security/Division of Developmental Disabilities (DES/DDD) and registered with the AHCCCS Administration. T/RBHAs must ensure adequate liability insurance before contracting with a Habilitation Provider, regardless if the provider is a DES certified individual or agency.

Prior to the delivery of behavioral health services, the Habilitation Provider must receive an orientation to the unique characteristics and specific needs of the eligible person under their care. Habilitation Providers must be informed regarding whom to contact in an emergency, significant events or other incidents involving the eligible person. The assigned clinician or designee is responsible for the timely review and resolution of any known issues or complaints involving the eligible person and a Habilitation Provider. Services provided by Habilitation Providers must be documented per ADHS/DBHS Policy 1.10, Behavioral Health Record Requirements. Further, the child and family team or the eligible person’s treatment team, as part of the service planning process, must periodically review services provided by Habilitation Providers.

Billing Questions…

Can Level II and III residential providers bill for bed hold days?

No. At this time billing separately for bed holds is limited to Residential Treatment Facilities. However, costs associated with items such as vacancy rates and bed holds may be factored into the per diem rate that is paid by the T/RBHA for Level II and III residential days.

Must all services provided to persons residing in Level II and III licensed residential facilities be included in the per diem rate?

Most services provided to persons in Level II and Level III residential facilities should be included in the per diem residential rate. This inclusive per diem rate does not preclude a Level II or III residential facility from subcontracting with other service providers and paying them from the per diem rate in order to ensure the delivery of appropriate services to the person, e.g., a therapist who may have previously been seeing the person. The following services are not included in the per diem rate and should be billed separately: services provided by independent practitioners who bill CPT/HCPCS; medications (using NDC codes); laboratory, radiology and medical imaging; emergency transportation services; and room and board services (S2000). In addition, provider agencies other than the residential facility may bill for case management, family support and peer support services provided to the person residing in and/or transitioning out of the residential setting. (See Appendix B8 in the Covered Behavioral Health Services Guide for a summary of covered services included in the per diem rates for Level II and III facility).

Modifier Added

Effective October 1, 2003, the following procedure codes have been approved to be billed as telemedicine using the GT modifier:

Procedure Code	Max Daily Units
99354 Prolonged Physician Service in the Office or Other Outpatient Setting	1
99355 Prolonged Physician Service in the Office or Other Outpatient Setting	6
99358 Prolonged Evaluation and Management Service Before and/or After	1
99359 Prolonged Evaluation and Management Service Before and/or After	6

What is an Institution for Mental Disease?

An Institution for Mental Disease (IMD) is defined at 42 CFR § 435.1009 as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care and related services. The regulations indicate that an institution is an IMD if its overall character is that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases. Title XIX of the Social Security Act provides that, except for individuals under age 21 receiving inpatient psychiatric care, Medicaid (Title XIX) does not cover services to IMD patients under 65 years of age [section 1905(a)(24)(B)]. Effective July 5, 2000, HCFA granted Arizona expenditure authority to provide limited services to Title XIX persons age 21 through 64 in IMDs. Based on current ADHS/OBHL licensing language, facilities which meet the definition of an IMD are licensed Level I facilities with more than 16 total treatment beds. General acute care hospitals with psychiatric units *are not* considered IMDs.

User Access Request Forms

The Office of Program Support Services must authorize all requests for access to CIS, Office of Human Rights, Office of Grievance and Appeals, and PMMIS (AHCCCS) databases. In order to obtain access to any of these databases, please fax a copy of the appropriate User Access Request Form and User Affirmation Statement to Stacy Mobbs at (602) 364-4736. For questions, please contact Stacy Mobbs by telephone at (602) 364-4708 or by e-mail at smobbs@hs.state.az.us.

Office of Program Support Staff

If assistance is needed, please contact your assigned Technical Assistant at:

Stacy Mobbs	Gila River Navajo Nation Pascua Yaqui	(602) 364-4708
Michael Carter	NARBHA PGBHA	(602) 364-4710
Eunice Argusta	CPSA-3 CPSA-5	(602) 364-4711
Javier Higuera	Excel Value Options	(602) 364-4712